Med-Pay, Inc.

Ozarks Technical Community College

2024 MEDICAL COVERAGE/RATE COMPARISON - Employee Monthly Premiums

	Base Plan		High Deductible Plan**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**
Individual Deductible	$1,000	$2,000	$1,600	$3,200
Family Deductible	$2,000	$4,000	$3,200	$6,400
Individual Maximum Out of Pocket*	$4,000	$9,500	$5,000	$10,000
Family Maximum Out of Pocket*	$8,000	$19,000	$10,000	$20,000
Coinsurance	20%	50%	20%	40%
	Embedded Deductible		**Aggregate (*Non-Embedded*) Deductible*** **	
Physician Services	ded + 20%	ded + 50%	ded + 20%	ded + 40%
Specialist Services	ded + 20%	ded + 50%	ded + 20%	ded + 40%
Inpatient Hospital	ded + 20%	ded + 50%	ded + 20%	ded + 40%
Outpatient Hospital	ded + 20%	ded + 50%	ded + 20%	ded + 40%
Urgent Care	$100	ded + 50%	ded + 20%	ded + 40%
Emergency Room	$300		ded + 20%	
Prescription Drug Deductible	$100		Medical Deductible Applies	
Prescription Drug Card	10/30/50/100	ded + 50%	ded + 20%	ded + 40%
Preferred Providers	Cox Network		Cox Network	

The employee cost is $0 for the Base and High Deductible plans when the employee receives the $150 monthly premium incentive by completing the two healthy activities as outlined by Human Resources. If not completed, the cost for all premiums listed below will increase by $150.

Monthly Rates:	**Employee**	**OTC**	**Employee**	**OTC**
Employee	$0.00	$644.00	$0.00	$537.00
Employee/Spouse	$546.00	$826.00	$456.00	$689.00
Employee/Children	$203.00	$711.00	$170.00	$593.00
Family	$778.00	$903.00	$650.00	$753.00

*** The Maximum Out of Pocket amounts illustrated above include ALL deductibles, coinsurance and copays (medical and prescription).**

**** $*107.00*/mo Contribution to Health Savings Account.**

***** The HDHP deductible is aggregate (non-embedded), and the out of pocket is embedded per ACA guidelines. Therefore, should one person in a family unit be incurring more claims than the other family members, that person would be subject to the family deductible ($3,200), but only the single out of pocket maximum ($3,400).**

THIS IS A SUMMARY OF COVERAGE for illustrative purposes only.

Please refer to your Cox HealthPlans Schedule of Benefits and corresponding Certificate of Coverage for plan details.

COX HEALTHPLANS
CoxHealth

Benefit Summary
Cox Health Systems Insurance Company
for Ozarks Technical Community College
PPO Group Health Plan

Partners 80

Covered Services	In-Network	Out-Of-Network
Essential Health Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible		
Per Covered Person	$1,000	$2,000
Per Family	$2,000	$4,000
Annual Maximum Out-of-Pocket	**(Including all Deductibles, Coinsurance and Copays)**	
Per Covered Person	$4,000	$9,500
Per Family	$8,000	$19,000
Physician Services	**Copay covers the physician consultation fee. All other services subject to deductible and coinsurance.**	
Primary Care Physician (PCP) Office Visit/Telemedicine (NON-INCLUSIVE)	20%* Coins	50%* Coins MAA**
Specialty Care Physician (SCP) Office Visit/Telemedicine (NON-INCLUSIVE)	20%* Coins	50%* Coins MAA**
Physician Services not received in an office setting	20%* Coins	50%* Coins MAA**
Diagnostic Laboratory, Imaging and Radiology	20%* Coins	50%* Coins MAA**
Inpatient Hospitalization	20%* Coins	50%* Coins MAA**
Outpatient Hospital Services	20%* Coins	50%* Coins MAA**
Hospital Emergency Room Services	$300 Copay	
Urgent Care Facility	$100 Copay	50%* Coins MAA**
Urgent Care Physician Services	$100 Copay	50%* Coins MAA**
Emergency Ambulance Services	20%* Coins	
Maternity & Childbirth Expenses	20%* Coins	50%* Coins MAA**
Preventive Health Services (Ages 0 to adult)		
Services with an "A" or "B" rating from the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	$0	50%* Coins MAA**
Additional preventive services or treatments not mandated by PHSA Section 2713	20%* Coins	50%* Coins MAA**
Preventive Health Services for Children and Adolescents		
Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration	$0	50%* Coins MAA**
Physician office visits and laboratory tests associated with preventive checkups	$0	50%* Coins MAA**
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	50%* Coins MAA**
Immunizations Ages 0 to Adult (per immunization)		
As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713, and as specified by the MO Department of Health and Senior Services regulations	$0	$12 Copay
Additional immunizations not mandated by PHSA Section 2713, or the MO Department of Health and Senior Services regulations	$12 Copay	$12 Copay
Home Health Care	20%* Coins	50%* Coins MAA**
Skilled Nursing Facility	20%* Coins	50%* Coins MAA**
Hospice Care	20%* Coins	50%* Coins MAA**
Durable Medical Equipment	20%* Coins	50%* Coins MAA**
Disposable Medical Supplies	20%* Coins	50%* Coins MAA**
Prosthetics	20%* Coins	50%* Coins MAA**
Orthotics	50%* Coins	50%* Coins MAA**
Chiropractic Services (Spinal Manipulation)	**Prior Authorization required for office visits in excess of 26 per benefit year**	
Office Visit	20%* Coins	50%* Coins MAA**
Other Services	20%* Coins	50%* Coins MAA**

Covered Services	In-Network		Out-Of-Network
Therapy Services (Not Including Chiropractic Services)****	**Annual Benefit of 60 visits (not including Applied Behavioral Analysis)**		
Physical Therapy	20%* Coins		50%* Coins MAA**
Occupational Therapy	20%* Coins		50%* Coins MAA**
Speech Therapy	20%* Coins		50%* Coins MAA**
Autism Spectrum Disorder (ASD) Services	**Benefits are based on the setting in which Covered Services are Received *******		
No limit to the number of visits for prior authorized ASD Services. The Therapy Services Annual Benefit of 60 visits does not apply to Autism Spectrum Disorder.			
Applied Behavior Analysis (ABA) - Requires prior authorization	20%* Coins		50%* Coins MAA**
No limit to the number of visits for prior authorized ABA. The Therapy Services Annual Benefit of 60 visits does not apply to Applied Behavioral Analysis.			
Dental Services (only related to accidental injury or for certain members requiring general anesthesia)	20%* Coins		50%* Coins MAA**
Mental Illness/Substance Use Disorder Services			
Office Visit	20%* Coins		50%* Coins MAA**
Other Services	20%* Coins		50%* Coins MAA**
Outpatient Treatment	20%* Coins		50%* Coins MAA**
Hospital Inpatient Treatment	20%* Coins		50%* Coins MAA**
Residential Treatment	20%* Coins		50%* Coins MAA**
Covered Education	20%* Coins		50%* Coins MAA**
Outpatient Prescription Drugs******	**Retail (30 day supply)**	**Mail*****	**Out-Of-Network**
Prescription Drug Deductible		$100	
Tier 1 - Most Generics (30 day supply)	$10 Copay	2.5 x Retail Copay	50%* Coins MAA**
Tier 2 - Preferred Brand (30 day supply)	$30 Copay	2.5 x Retail Copay	50%* Coins MAA**
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	$50 Copay	2.5 x Retail Copay	50%* Coins MAA**
Tier 4 - Specialty Formulary Brand (30 day supply)	$100 Copay	Not available	Not available
Tier 5 - Preventive	$0	$0	Not available

* Coinsurance applies after Deductible is met.

** MAA is used as an abbreviation for Maximum Allowable Amount.

*** Mail order available on maintenance medications only for a 90 day supply (Copay will be 2.5x Retail)

****Copays/Coinsurance for Physical Therapy and Occupational Therapy will not exceed the physician office visit once the deductible is met.

***** Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/Co-pay/Co-insurance than is applicable to other physical health care services covered by this Plan.

****** If a Provider, Pharmacy, or any third party payer waives, discounts, reduces, or indirectly pays the required cost sharing for a particular claim; the waived portion, discounted portion, reduced portion, or indirectly paid portion of the cost share will not apply to or reduce any Deductible or Out-of-Pocket applicable to the Plan.

This is only a brief summary of benefits, which is not intended to be comprehensive. Your Certificate of Coverage is the governing document for benefit information.

COX HEALTHPLANS
CoxHealth

Benefit Summary
Cox Health Systems Insurance Company
for Ozarks Technical Community College
PPO Group Health Plan

HDHP 80

Covered Services	In-Network	Out-Of-Network
Essential Health Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible (non-embedded: Individuals with Family coverage are subject to the Family deductible before Single coinsurance applies**)**		
Per Covered Person	$1,600 (EO) / $3,200 (ES, EC, FA)	$3,200 (EO) / $6,400 (ES, EC, FA)
Per Family	$3,200	$6,400
Annual Maximum Out-of-Pocket (embedded)	**(Including all Deductibles and Coinsurance)**	
Per Covered Person	$5,000 (EO) / $6,600 (ES, EC, FA)	$10,000 (EO) / $13,200 (ES, EC, FA)
Per Family	$10,000	$20,000
Physician Services		
Primary Care Physician (PCP) Office Visit/Telemedicine	20%* Coins	40%* Coins MAA**
Specialty Care Physician (SCP) Office Visit/Telemedicine	20%* Coins	40%* Coins MAA**
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Diagnostic Laboratory, Imaging and Radiology	20%* Coins	40%* Coins MAA**
Inpatient Hospitalization	20%* Coins	40%* Coins MAA**
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Hospital Emergency Room Services	20%* Coins	
Urgent Care Facility	20%* Coins	40%* Coins MAA**
Urgent Care Physician Services	20%* Coins	40%* Coins MAA**
Emergency Ambulance Services	20%* Coins	
Maternity & Childbirth Expenses	20%* Coins	40%* Coins MAA**
Preventive Health Services (Ages 0 to adult)		
Services with an "A" or "B" rating from the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	$0	40%* Coins MAA**
Additional preventive services or treatments not mandated by PHSA Section 2713	20%* Coins	40%* Coins MAA**
Preventive Health Services for Children and Adolescents		
Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration	$0	40%* Coins MAA**
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Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	40%* Coins MAA**
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As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713, and as specified by the MO Department of Health and Senior Services regulations	$0	40%* Coins MAA**
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Covered Education	20%* Coins		40%* Coins MAA**
Outpatient Prescription Drugs******	**Retail (30 day supply)**	**Mail*****	**Out-Of-Network**
Prescription Drug Deductible	$1,600 Medical Deductible		
Tier 1 - Most Generics (30 day supply)	20%* Coins	20%* Coins	40%* Coins MAA**
Tier 2 - Preferred Brand (30 day supply)	20%* Coins	20%* Coins	40%* Coins MAA**
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	20%* Coins	20%* Coins	40%* Coins MAA**
Tier 4 - Specialty Formulary Brand (30 day supply)	20%* Coins	Not available	Not available
Tier 5 - Preventive	$0	$0	Not available

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Dental Insurance

Sun Life

COMMONLY COVERED

- Exams and cleanings
- X-rays
- Fillings
- Tooth extractions
- Child braces

PROTECTS YOUR SMILE.

You can feel more confident with dental insurance that encourages routine cleanings and checkups. Dental insurance helps protect your teeth for a lifetime.

PREVENTS OTHER HEALTH ISSUES.

Just annual preventive care alone can help prevent other health issues such as heart disease and diabetes. Many plans cover preventive services at or near 100% to make it easy for you to use your dental benefits.

LOWERS OUT-OF-POCKET EXPENSES.

Seeing an in-network dentist can reduce your fees approximately 30% from their standard fees. Add the benefits of your coinsurance to that and things are looking good for your wallet.

DENTAL FAST FACTS

Periodontal disease can lead to receding gums, bone damage, loss of teeth, and can increase the risk of other health problems such as heart disease and diabetes.1

Treatment of gum disease in people with type 2 diabetes can lower blood sugar over time.2

OZARK TECHNICAL COMMUNITY COLLEGE

All Eligible Employees

POLICY # 942059

What's covered

Good news! *Your plan covers routine services like cleanings and exams at* ***100%.***

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type II, III (Basic and Major Services)	$1,500 per person	$1,500 per person
Type IV Ortho Service	$1,500 lifetime per child	$1,500 lifetime per child

Type I Preventive Services do not count toward your Calendar Year maximum

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	90%	90%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any 12 month period
- Routine dental cleanings – 1 in any 6 month period
- Fluoride treatment – 1 in any 6 month period. *Only for children under age* 19
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age 16*
- Space maintainers – *only for children under age 19*
- Bitewing x-rays – 2 in any calendar year
- Intraoral complete series x-rays – 1 in any 36 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 1 in any 6 consecutive months
- Localized delivery of antimicrobial agents
- Stainless steel crowns – *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Complex oral surgery
- General anesthesia/IV sedation – medically required

Type IV Ortho Services, including:

- Orthodontic treatment is limited to the dependent children or student age listed above

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic or major services
- No waiting period for orthodontic services

Frequently asked questions

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists.

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[3] and dependent children. An eligible child is defined as a child to age 26.[4]

What if I have already started dental work, like a root canal or braces, that requires several visits?
Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?
Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage or find my dental ID card?
After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app—*Benefit Tools*, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

What value added benefits does my plan include?
Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer.

Your plan also includes Preventive Max Waiver® which allows covered dental expenses for preventive services to not apply to the annual maximum.

CONSIDER A PRE-DETERMINATION OF BENEFITS

They allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. We recommend them for any dental treatment expected to exceed $300.

1. American Academy of Periodontology http://www.perio.org/consumer/love_the_gums_you%27re_with. (accessed on 06/06/19)
2. https://www.cdc.gov/diabetes/ndep/pdfs/150-Healthy-teeth-matter.pdf (accessed 06/06/19)
3. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
4. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions

Important information

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Late entrant

If you or a dependent apply for dental insurance more than 31 days after you become eligible, you or your dependent are a late entrant. The benefits for the first 12 months for late entrants will be limited as follows:

TIME INSURED CONTINUOUSLY UNDER THE POLICY	BENEFITS PROVIDED FOR ONLY THESE SERVICES
Less than 6 months	Preventive Services
At least 6 months but less than 12 months	Preventive Services and fillings under Basic Services
At least 12 months	Preventive, Basic, Major and Ortho Services

We will not pay for treatments subject to the late entrant limitation, and started or completed during the late entrant limitation period.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Dental

We will not pay a benefit for any Dental procedure, which is not listed as a covered dental expense. Any dental service incurred prior to the Effective date or after the termination date is not covered, unless specifically listed in the certificate. A member must be a covered dental member under the Plan to receive dental benefits. The Plan has frequency limitations on certain preventive and diagnostic services, restorations (fillings), periodontal services, endodontic services, and replacement of dentures, bridges and crowns. All services must be necessary and provided according to acceptable dental treatment standards. Treatment performed outside the United States is not covered, except for emergency dental treatment, subject to a maximum benefit. Dental procedures for Orthodontics; TMJ; replacing a tooth missing prior the effective date; implants and implant related services; or occlusal guards for bruxism are not covered unless coverage is elected or mandated by the state.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

This plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act (PPACA).

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-DEN-C-01.

GVBH-EE-8384 SLPC 29579

Rates

Coverage and **monthly** cost for Dental.

Rates are effective as of January 01, 2024.

Dental coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Coverage	Cost per pay period*
Employee	$0.00
Employee + Spouse	$32.15
Employee + Child(ren)	$45.74
Employee + Family	$78.04

*Contact your employer to confirm your part of the cost.

Rate Sheet

Employee- coverage and **monthly** cost for Employee Voluntary Life.
Rates are effective as of January 1, 2024.
The chart below shows possible coverage amounts and corresponding cost per month.
Find your age bracket (as of the effective date of coverage) to determine the cost for coverage.

Age and Cost -Employee											
Covergae Amount	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	0.56	0.56	0.64	0.88	1.20	2.08	3.20	6.24	7.68	11.04	11.04
$20,000	1.12	1.12	1.28	1.76	2.40	4.16	6.40	12.48	15.36	22.08	22.08
$30,000	1.68	1.68	1.92	2.64	3.60	6.24	9.60	18.72	23.04	33.12	33.12
$40,000	2.24	2.24	2.56	3.52	4.80	8.32	12.80	24.96	30.72	44.16	44.16
$50,000	2.80	2.80	3.20	4.40	6.00	10.40	16.00	31.20	38.40	55.20	55.20
$60,000	3.36	3.36	3.84	5.28	7.20	12.48	19.20	37.44	46.08	66.24	66.24
$70,000	3.92	3.92	4.48	6.16	8.40	14.56	22.40	43.68	53.76	77.28	77.28
$80,000	4.48	4.48	5.12	7.04	9.60	16.64	25.60	49.92	61.44	88.32	88.32
$90,000	5.04	5.04	5.76	7.92	10.80	18.72	28.80	56.16	69.12	99.36	99.36
$100,000	5.60	5.60	6.40	8.80	12.00	20.80	32.00	62.40	76.80	110.40	110.40
$110,000	6.16	6.16	7.04	9.68	13.20	22.88	35.20	68.64	84.48	121.44	121.44
$120,000	6.72	6.72	7.68	10.56	14.40	24.96	38.40	74.88	92.16	132.48	132.48
$130,000	7.28	7.28	8.32	11.44	15.60	27.04	41.60	81.12	99.84	143.52	143.52
$140,000	7.84	7.84	8.96	12.32	16.80	29.12	44.80	87.36	107.52	154.56	154.56
$150,000	8.40	8.40	9.60	13.20	18.00	31.20	48.00	93.60	115.20	165.60	165.60
$160,000	8.96	8.96	10.24	14.08	19.20	33.28	51.20	99.84	122.88	176.64	176.64
$170,000	9.52	9.52	10.88	14.96	20.40	35.36	54.40	106.08	130.56	187.68	187.68
$180,000	10.08	10.08	11.52	15.84	21.60	37.44	57.60	112.32	138.24	198.72	198.72
$190,000	10.64	10.64	12.16	16.72	22.80	39.52	60.80	118.56	145.92	209.76	209.76
$200,000	11.20	11.20	12.80	17.60	24.00	41.60	64.00	124.80	153.60	220.80	220.80

Age and Cost - Spouse											
Covergae Amount	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
5,000	0.28	0.28	0.32	0.44	0.6	1.04	1.6	3.12	3.84	5.52	5.52
10,000	0.56	0.56	0.64	0.88	1.2	2.08	3.2	6.24	7.68	11.04	11.04
15,000	0.84	0.84	0.96	1.32	1.80	3.12	4.80	9.36	11.52	16.56	16.56
20,000	1.12	1.12	1.28	1.76	2.40	4.16	6.40	12.48	15.36	22.08	22.08
25,000	1.40	1.40	1.60	2.20	3.00	5.20	8.00	15.60	19.20	27.60	27.60
30,000	1.68	1.68	1.92	2.64	3.60	6.24	9.60	18.72	23.04	33.12	33.12
35,000	1.96	1.96	2.24	3.08	4.20	7.28	11.20	21.84	26.88	38.64	38.64
40,000	2.24	2.24	2.56	3.52	4.80	8.32	12.80	24.96	30.72	44.16	44.16
45,000	2.52	2.52	2.88	3.96	5.40	9.36	14.40	28.08	34.56	49.68	49.68
50,000	2.80	2.80	3.20	4.40	6.00	10.40	16.00	31.20	38.40	55.20	55.20

Covergae Amount	Child(ren) Cost
$10,000	2.59
$20,000	5.18

Vision Insurance

Sun Life

COMMONLY COVERED

- Annual exams
- Lenses
- Frames
- Contact lenses
- Laser vision correction discount

PROTECTS YOUR EYES.

You can help protect your eyesight by visiting an eye doctor regularly. Vision insurance includes an annual comprehensive eye exam with an eye care doctor. Taking care of your eyes today can lead to a better quality of life later.

PREVENTS OTHER HEALTH ISSUES.

Just annual preventive care alone can help detect signs of chronic health conditions such as high blood pressure and diabetes. Early detection can be key before costly symptoms arise.[1]

LOWERS OUT-OF-POCKET EXPENSES.

Seeing an in-network eye care provider can reduce your expenses with savings on frames, lenses, contacts, eye exams and more.

VISION INSURANCE FAST FACTS

Roughly, 90% of diabetes-related blindness can be avoided by getting an annual eye exam.[2]

59% of adults report experiencing symptoms of digital eye strain, such as blurred vision or headaches.[3]

OZARK TECHNICAL COMMUNITY COLLEGE

All Eligible Employees

POLICY # 942059

Sun Life Assurance Company of Canada

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What's covered

BENEFIT	FREQUENCY	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Exam services			
WellVision exam®	**1 per 12 months**	**$10 for exam**	**Up to $45**
Routine retinal screening		**No more than a $39 copay**	**N/A**
Laser vision correction discount	**Once per eye per lifetime.**	**Average 15% off the regular price or 5% off the promotional price.** **Discounts only available from contracted facilities.**	**N/A**
Lenses			
Single lined	**1 per 12 months**	**$25 (lenses and frame)**	**Up to $30**
Bifocal lined			**Up to $50**
Trifocal			**Up to $60**
Lenticular			**Up to $100**
Necessary contacts			**Up to $210**
Lens enhancements			
Standard		**$55 copay**	**N/A**
Premium progressive		**$95-$105 copay**	**N/A**
Custom progressive		**$150–$175 copay**	**N/A**
Other		**Average savings of 20-25%**	**N/A**
Frames	**1 per 24 months**	**$130 for the frame of your choice and 20% off the amount over your allowance** **$70 allowance at Costco® and Walmart®***	**Up to $70**
Elective contact lenses *Contact lenses are in place of lenses and frame.*	**1 per 12 months**	**15% savings for your contact lens exam (fitting and evaluation)** **$130 for contact lenses**	**Up to $105**
Additional glasses and sunglasses discount	**20% off complete pairs of prescription and non-prescription glasses, including sunglasses. Discounts are unlimited for 12 months following exam.**		**N/A**
Coverage with retail providers	***Coverage with retail providers may be different. Check with Costco for VSP member pricing. Costco and Walmart allowance is equivalent to the allowance at preferred providers and other retail providers.**		

This chart outlines services for Plan 3.

Administrative services for the vision insurance plan are provided by Vision Service Plan (VSP).

Frequently asked questions

How do I use my vision benefit?

Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. If you visit an in-network doctor for services and materials, you don't need an ID card or have forms to complete.

How do I locate an in-network VSP doctor?

You will have access to the largest national network[4] of private-practice eye care doctors in the industry through Vision Service Plan (VSP). There are three ways to find an in-network doctor:

1. Visit vsp.com and select the Choice network.
2. Call VSP at 800-877-7195.
3. Download our mobile app, Benefit Tools, and search for a doctor near you.

What happens if I use an out-of-network doctor?

You will be required to pay the full amount to the doctor at time of service. You can then submit a claim for reimbursement, which is a lesser benefit when compared to visiting a VSP doctor.

When will my coverage become effective?

Your coverage starts on the effective date specified in your group policy, provided you are actively at work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties.

Can I enroll as a late entrant?

If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

Are my dependents eligible for coverage?

Yes. Your plan offers coverage for your spouse[5] and dependent children. An eligible child is defined as a child to age 26.[6]

How can I get more information about my coverage?

After the effective date of your coverage, you can visit www.sunlife.com/account to create a Sun Life account. Once you're logged in, you'll be able to see your plan details and more. Or you can call VSP Customer Service at 800-877-7195.

Can I use my benefits to buy glasses or contacts online?

Absolutely. Just visit www.eyeconic.com. Once you have linked your benefits you will be able to see how your coverage will be applied to different options that you are reviewing. Eyeconic features a virtual try-on tool so you can see how the glasses will look on you before you make your purchase.

1. https://vsp.com/eye-symptoms.html accessed 03/13/19.
2. https://www.vsp.com/diabetes.html accessed 03/13/19.
3. The Vision Council https://www.thevisioncouncil.org/content/digital-eye-strain accessed on 02/21/19.
4. Netminder as of December 2018.
5. If permitted by the Employer's benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
6. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions.

Important information

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below conditions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Vision

We will not pay a benefit for any vision materials, services or options that are not shown in the Benefit Highlights section of the certificate. Any vision service incurred prior to the Effective date or after the termination date is not covered. A member must be a covered vision member under the Plan to receive vision benefits. In no event will benefits exceed the lesser of the actual cost of the examination or materials or the limits of coverage shown in the Benefit Highlights section of the certificate. The plan is designed to cover visually necessary materials rather than cosmetic materials; the member will be responsible for any additional costs above the basic cost.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

This vision plan does not provide coverage for pediatric vision health services that satisfies the requirement for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act ("PPACA").

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-VIS-C-01.

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Rates

Coverage and **monthly** cost for Vision.

Rates are effective as of January 01, 2024.

Vision coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Coverage	Cost per pay period*
Employee	$6.55
Employee + Spouse	$13.28
Employee + Child(ren)	$14.23
Employee + Family	$20.34

*Contact your employer to confirm your part of the cost.